

JAN 13 1938

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH

County..... Registration District No. **791**
Township..... Primary Registration District No. **1003**
City **#2 Hospital** (No. **en route**, City Hospital No. **2**, St. Ward)

41280

File No.
Registered No. **10496**

2. FULL NAME

Nellie Paine Nellie Paine

(a) Residence, No. **3025 Madison St.** / / Ward.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **Col.** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Married**
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Will**
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **11/30/1890**
AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. **30 - - 7**

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. **House Keeper**
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. **at home**
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Abbeville Miss.**

13. NAME **Robert Walton**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Abbeville Miss.**

15. MAIDEN NAME **Katie Pruitt**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Abbeville Miss.**

17. INFORMANT **Will Paine**
(ADDRESS) **3025 Madison St.**

18. BURIAL, CREMATION, OR REMOVAL
PLACE **First Station** DATE **Dec. 12**, 19**37**

19. UNDERTAKER **Tanner and Co. (Tanner)**
(ADDRESS) **2924 Dickson**

20. FILED **DEC 13 1937** **J. Bredeck**
Registrar.

MEDICAL CERTIFICATE OF DEATH

No physician in attendance
21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Dec. 2**, 19**35**

22. I HEREBY CERTIFY, That I attended deceased from 19....., to..... 19.....
I last saw h..... alive on..... 19..... Death is said to have occurred on the date stated above, at **4:15 P.**
The principal cause of death and related causes of importance were as follows:
Cerebral Apoplexy.

Other contributory causes of importance: **82 at**

Name of operation Date of
What test confirmed diagnosis? Was there an autopsy? **No.**

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury 19.....
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) **Frank P. Furlong**, M. D.
(Address) **by map**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

